DR. NAME ____

ADDRESS ____

CITY ______________________________ STATE ______

ZIP ____________ PHONE# ________________________

TO PREFERRED

TCS PROCESSING DENTAL LABORATORY:

____

____

DUE IN OFFICE BY 5PM ON:

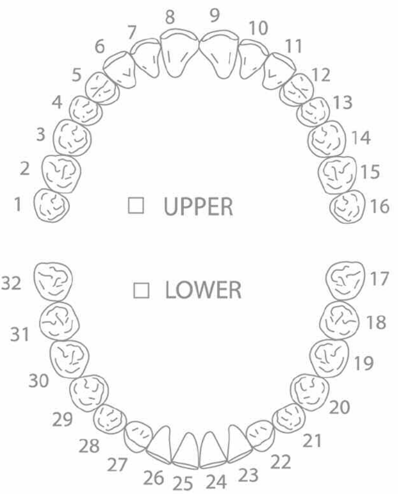
____

PATIENT'S INFORMATION: (Please Print)

NAME (LAST): ______________________________ (FIRST): ___________________________

AGE: ____________ SEX: ❒ MALE ❒ FEMALE

Rx Specific Instructions:



LICENSE #: ______________________ SIGNATURE: ____

❒ FINISH ❒ TEETH TRYIN ❒ RESET TEETH ❒ BITE BLOCK

TOOTH SHADE: ______________________

PARTIALS:

- ❒ TCS UNBREAKABLE PARTIAL
- ❒ TCS COMBINATION W/ METAL FRAME
- ❒ TCS UNILATERAL
- ❒ OTHER ________________

TISSUE SHADE:

- ❒ LIGHT PINK
- ❒ STANDARD
- ❒ ETHNIC/DARK
- ❒ OTHER ________________

WHITE – LAB'S COPY • YELLOW – DOCTOR'S COPY